Proposed Strategy for Future USAID Support to the Well-family Midwife Clinic Franchise Network

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ACRONYMS

ACNM	American College of Nurse-Midwives
AIDS/HIV	Acquired Immune Deficiency Syndrome (AIDS)
ARMM	
BHW	
CFPOI	
CHO	
COMDEV	
COO	Chief operating officer
CPA	
CPR	Contraceptive prevalence rate
CY	Calendar year
DCA	
DMSF-CERDH	
DOH	Department of Health
FORFIL	
FP	Family planning
FranCorp	
GOP	Government of the Philippines
HFC	
IMCCSDI	
IMCH	
JSI	John Snow International
KFI	
LEFADO	
LGU	
MCH	Maternal and child health
MEDS	Monitoring, Evaluation, and Design Support Project
NCR	
NGO	Non-governmental organization
NORFI	
OTC	Over the counter
PhilHealth	
PHN	Public health and nutrition
PHP	
RHU	
RMA	
RTI	Research Triangle International
SDI	
TANGO	Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations
USAID	United States Agency for International Development
WF	Well-Family

WFMC	Well-Family Midwife Clinic
WFPI	Well-Family Midwife Clinic Partnerships Foundation, Inc

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EXECUTIVE SUMMARY

Consultancy assistance was requested by USAID/Philippines through the MEDS Project to develop a draft strategy for future USAID support to the Well-family Midwife Clinic (WFMC) franchise network. USAID/Philippines wished to ensure a smooth transition of the franchise management from John Snow International/Research Triangle International (JSI/RTI) to the Well-family Partnerships Foundation, Inc., that was established to sustain the business and social development operations of the network. A three-person consultancy team assessed the status and adequacy of the current WFMC business franchise system, and its prospects for successfully expanding and sustaining the network during coming years.

The many success stories of Well-family (WF) midwives repeatedly demonstrate that a private sector program can work successfully in complementing public sector efforts to meet the demand for quality family planning/maternal child health (FP/MCH) services. One of the greatest achievements of the program is the remarkable transformation of participating midwives from ordinary health care providers to successful entrepreneurs demonstrating confidence, professional status, and earning capacity while making contributions to national safe motherhood and family planning objectives.

The consulting team believes that the transformation of a project for service delivery to a commercial franchise system is not simple. It requires serious study, capital funds, and a considerable amount of time and technical assistance for institutional and business development.

It appears to the consulting team that most of the WF clinics are financially sustainable at the operational level (i.e., reporting an operating profit) within twelve months of service delivery start-up. What remains less clear, however, is the extent to which the WF partnership/foundation can operate effectively while keeping recurrent costs sufficiently low so that they can be supported by the fees and royalties generated by these operationally sustainable clinics.

Of the existing 210 WF clinics, twenty-seven had average gross monthly revenues of P50,000, or more, in calendar year (CY) 2002, according to JSI data provided. Sixty-five clinics (including the 27 above) reported average monthly gross revenues of P25,000 or more for CY 2002. In the same year, 154 of the 210 clinics reported a total annual operating profit of P25,000 or more. (Table VI: Sales and Operating Cost Performance, Col. 6, 36 clinics from page 1, 42 clinics from page 2, 39 clinics from page 3, 20 clinics from page 4, and 17 clinics from page 5.) These numbers assume that clinic record keeping is accurately reported, and that costs and revenues have been appropriately and consistently allocated across the network. Currently, there is no way to validate these numbers since they are not audited or utilized for any official purpose such as payment of taxes.

There appears no analysis yet of tolerance on the part of the target population of potential franchise purchasers for the level of financial risk posed by an P800,000 start-up cost which includes a P200,000 franchise fee. While the consulting team is inclined to recommend the assessment of a "conversion fee" on existing WF clinic owners as part of the transition to a commercial franchise system, in order to create a greater sense of equity between current clinic

owners and future franchise purchasers, there is no indication of the affordability and acceptability of a conversion fee among existing clinic owners. The profile of WF franchise clinics implied by current estimated start-up costs of P800,000 is significantly different from the profile of current WF clinics implied in reported annual gross revenue.

The consulting team has identified a number of tasks related to the institutional capability of the partnership/foundation and development of the WF franchise system that are critical to expansion and sustainability of the WF clinic network, but which are currently incomplete or not yet sufficient for the task. These insufficiencies must be resolved before expansion. Consequently, during the next eighteen months, the WF partnership/foundation should concentrate on the following steps for improvement:

- Hire an appropriately qualified Chief Operating Officer (COO)/Executive Director;
- Strengthen the composition of the Board of Directors by adding a significant number of commercial and business people;
- Complete and implement the operational and financial systems throughout the WF clinic network;
- Develop and initiate access to low-cost credit for participating midwives;
- Define the franchise product, verifying the feasibility of the franchise model;
- Further develop franchise and clinic level marketing tools;
- Secure PhilHealth and DOH accreditation for relevant clinics; and
- Convert existing clinics to the commercial franchise system.

These tasks are all critically important to the long term success and sustainability of the WF franchise and require, in the opinion of the team, the full focus of partnership and JSI attention in order to be completed before the end of CY2004.

This is a formidable list of necessary tasks and will require technical assistance from a variety of sources for timely completion. The team believes that continuing assistance from FranCorp Philippines in franchise system development and franchise marketing is necessary, in addition to the services of an accounting and auditing firm for the development and institutionalization of financial systems and control. These financial systems should extend down to the level of the clinic and should include assistance to each participating midwife in installing and correctly utilizing a uniform chart of accounts and financial statements. The financial system, once fully established, will facilitate: 1) preparation of the franchise's overall financial projections; 2) marketing the franchise as a viable investment opportunity to potential franchisees; 3) validation of the foundation's sustainability prospects; 4) application for low-cost credit by clinic managers; and 5) monitoring and collection of franchise fees.

Additionally, maintaining and growing the service delivery business of existing WF clinics are fundamental not only to the future sustainability of the WFPI but also for impact of the WF franchise on the reproductive health status of Filipino women. Currently, the pattern of growth among WF clinics is not consistent; the level of effort expended on marketing each clinic within its community is left largely to the personal inclinations of each clinic owner. The potential for considerable expansion of WF service delivery can be seen in the severely overcrowded conditions of many public sector obstetric outlets. The WF midwives estimate that, on average, up to twenty deliveries per month could be handled in existing clinics without expansion (eleven is the current monthly average of WF deliveries per clinic.) System-wide expectations for clinic business growth (perhaps stated as a percentage of the previous year's business, number of FP clients, etc.) should be drawn up and disseminated throughout the WF system. Clinic managers should understand from the start of their participation in the franchise that clinics that do not meet these expectations over a given period will be "deselected" from the franchise.

Technical assistance from JSI will be necessary during the next eighteen months, particularly in developing an expanded and standardized package of clinic and community level marketing strategies, and institutionalizing implementation of these strategies by all midwife-owners. The team believes that WF supervisors should work with each participating midwife to develop an annual goal for business growth (including growth in the number of family planning clients). Clinic performance in moving toward and achieving the annual goal should be monitored. Non-performing and low-performing clinics should receive systematic remedial marketing counseling during the course of the year.

JSI technical assistance will also be critical during the period from the present to the end of December 2004, in coordinating and liaising with the various other entities providing technical assistance in the development of the Well-family Midwife Clinic Partnerships Foundation, Inc (WFPI) franchise system, in providing planning and policy support to the WFPI Board of Directors, and in monitoring the financial and service delivery outcomes of the WF network. USAID funds for continuing support to the WFPI network will flow easily through the JSI cooperative agreement mechanism until its expiration on December 31, 2004.

The role of non-governmental organizations (NGOs) in the network with regards to the WF partnership entity needs clarification. Six NGOs currently provide supervision to WF midwives operating within their geographic territories. Two of these NGOs (SDI and IMCH) are also DOH-accredited training institutions and provide the training given to each WF midwife. Day to day supervision and support of WF midwives by local NGOs appear to provide important "glue" in holding together the WF network and in creating and maintaining midwife loyalty to the WF partnership and nationwide system.

During the next eighteen months, the WFPI needs to formulate a specific strategy (perhaps subcontracting for supervisory services that do not in themselves generate revenue, and subcontracting for training on a fee per paying participant basis, for example) for continuing the successful participation of NGOs in the WF network. One very important issue that must be addressed in this strategy is the separation of NGO supervisory responsibilities from auditing and evaluative tasks that should be undertaken by an independent entity. Well-Family experience to

date indicates that NGOs developing and nurturing midwife participants do not effectively supply the regulatory discipline necessary for a successful commercial franchise operation.

To ensure that sufficient attention is provided to the many critical tasks outlined above, the team strongly suggests that only those clinics whose midwife managers have already begun spending funds to renovate and create their WF clinic sites should be opened between the present date and December 31, 2004. The team believes that this number is limited to twenty-one clinics. No other new clinics should be opened or new franchises sold until January 1, 2005, at which time it is anticipated that the WF franchise system will be solidly in place.

The team believes that the current business plan of the WF partnership/foundation outlines an organizational structure that is top heavy and that unrealistically relies on full-time staff (as opposed to the possibilities of out-sourcing) for early achievement of sustainability goals. Further partnership expenditures for equipment and office furniture should be largely deferred until after December 31, 2004 when TANGO Project equipment and furniture will likely revert to USAID and could, perhaps, be transferred at little or no cost to the partnership. The six-year horizon for break-even projected in the WFPI business plan exceeds the generally accepted commercial standards of three years for new business sustainability.

The team believes that WFPI will require some level of external financial support through CY2006 if the commercially accepted break-even horizon of three years is used. Continued USAID support for the next three years is essential to achieve the sustainability goals of the foundation, particularly the preparation for the transition of the existing clinic network into commercially viable franchise units. This support should include at least the following: 1) JSI should continue its role during the next eighteen months in facilitating this transition; 2) FranCorp should provide over the three-year period technical assistance and supervision to support the full development of both the existing clinic network and the new franchise clinics into completely viable commercial enterprises; 3) an auditing/accounting agency should develop and install a standardized accounting system that will serve as the basis for financial projections and financial monitoring, and royalties collection; and 4) a contributions capital pool from which franchise clinics can draw start-up capital or building expansion needs. USAID funding support after December 2004 should be contingent upon the WFPI's achievement of mutually agreed upon business and service delivery goals.

During the period from the present through December 31, 2004, USAID funding support for WF-related activities can be funneled through the JSI cooperative agreement. The mechanism available for USAID funding support after January 1, 2005 through December 31, 2006 is not clear and would have to be consistent with current USAID regulations requiring local grant or cooperative agreement recipients to have a three-year track record and audited financial statements.

USAID may also wish to provide some type of limited, longer term (post 2006) assistance to WFPI in view of the reproductive health and social development agenda of the partnership. Such longer term, though limited, funding involvement might also provide USAID with continuing leverage on partnership policy and service delivery priorities.

The team has identified several mechanisms available to USAID for longer term, limited funding as follows:

- Creation of an endowment; or
- Capital investment in a designated number of partnership-owned WF clinics;
    - DCA backing for low-cost loans to the partnership, or
    - DCA-backed loan trust

I. INTRODUCTION

BACKGROUND

The growth rate of the Philippine population has proceeded at an annual average of 2.36% from 1995 to 2000. At the current rate, and with nearly half of the more than 80 million population under 20 years old, it is expected that the population will double and may reach 160 million in about 30 years. If not curbed, this growth rate will continue to impede economic progress and seriously hamper the government's capacity to provide jobs and essential services.

Studies show that goals for poverty reduction will be difficult to achieve "unless a concerted population management program is put in place to check the prevailing high population growth rate." The family planning program of the Philippines has not been successful as desired. The modern method contraceptive prevalence rate (CPR) is 35.1% in 2002, compared to its Asian neighbors such as Thailand, which is 70%. The greatest challenge for family planning is to increase modern CPR by over 40% (that means about 6.2 million women using modern contraceptive methods) if couples are to achieve desired family size. The high level of unmet need for family planning services is seen in the significant disparity between the total fertility rate (3.7) and reported desired family size (2.7). Certainly, achieving the desired increase in CPR and satisfying unmet need for family planning cannot be accomplished by the public sector alone, given current government resources.

A large and innovative private sector remains a major under-utilized asset for delivery of basic services such as family planning. Its support of achieving family planning goals through service delivery may help reduce the population growth rate and consequently contribute to economic development.

For more than three decades, USAID has supported the GOP in the promotion of family planning services and in improving maternal and child health. Experience however, has shown that the public sector health service delivery model at the national level and even at the LGU level has not produced desired results. USAID has indicated that it will no longer provide funding assistance for public sector contraceptive supplies but will focus its efforts on helping the GOP achieve contraceptive self-reliance. This shift means that future assistance must promote the expansion of services by the private sector, both to meet current needs and to ensure sustainability of service provision in the future.

THE MODIFIED TANGO 11 PROJECT

In 1995, JSI Research and Training Institute (JSI/RTI), through the funding assistance of USAID, embarked on a program called "Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations" (TANGO**).** Dubbed "a model program of private sector principles serving the public good," the TANGO project's initial approach was to build sustainable NGO-supported family planning programs by strengthening NGO management capacity. After an in depth assessment in 1996, TANGO II was focused on the development of an alternative private sector

model for the provision of family planning and maternal and child care (FP/MCH). Thus in 1997, in partnership with eight NGOs based in various regions, the project started the establishment of a network of clinics owned and managed by midwives who deliver family planning and maternal and child health services to the C and D economic segments of the population in key urban areas and selected municipalities of the Philippines.

The centerpiece of the TANGO II project is the Well-Family Midwife Clinic. It aims to bring affordable, quality and convenient family planning, maternal and child health (FP/MCH) services to more Filipinos while providing businesses to midwives all over the country and unloading public health facilities of clients who can afford to pay. As a social enterprise, the project highlights entrepreneurship, ownership, and empowerment as central themes reflected in a franchise-type service delivery model that combines business and social development concepts, principles, and best practices.

There are now 210 clinics in 29 provinces in the Philippines that provide accessible and affordable quality health care services to Filipinos who are unable to pay the full costs of most private sector-provided health services, yet who can afford to pay reasonable fees. Through these clinics, the role of the midwife has been transformed from ordinary health care provider to entrepreneur, thereby enhancing her confidence, professional status, and earning capacity.

THE WELL-FAMILY MIDWIFE CLINIC PARTNERSHIPS FOUNDATIONS, INC.

To sustain their businesses and social development operations, the WFMC midwives and their partner NGOs have formed the Well-family Midwife Clinic Partnerships Foundation, Inc. (WPFI). Registered with the Securities and Exchange Commission on June 18, 2002, WPFI envisions itself as "a leading and sustainable national organization nurturing a network of excellent community-based clinics and health service providers that ensure family wellness through family planning and maternal and child care services."

The stated mission of the WPFI is to:

- Ensure effectiveness and sustainability of WFMCs;
- Manage the “Franchise System” of WFMC brand;
- Deliver essential services including research and development, training and organizational needs of WFMCs; and
- Address family planning and maternal and child health (FP/MCH) concerns at the community level.

To ensure effectiveness and sustainability of WFMCs in increasing availability of FP/MCH services in the private sector, the foundation will manage the franchise system that assists midwives in becoming independent owners of fully sustainable FP/MCH facilities. Among its programs to ensure well-enforced and supervised service delivery mechanisms and standards for

WFMCs are Franchise Development, Business Development and Consultancy Services, Marketing, and Human Resource Development.

USAID STRATEGIC OBJECTIVE

USAID's PHN Results Framework 2002-2006 is focused on approaches that will improve and expand delivery of key health services so that "desired family size and improved health status are sustainably achieved." Achievement of the WFMC project objectives is in sync with USAID's IR2: *Provision of quality services by private and commercial providers expanded,* and IR3: *Greater social acceptance of family planning achieved.* To achieve these objectives, USAID supports projects that strengthen and expand the private sector as an alternative source of FP/MCH services such as the FriendlyCare Foundation, Inc., and the Well-family Midwife Clinic Network of the JSI/RTI TANGO 11 Project. USAID also supports "full cost recovery" marketing of an oral contraceptive pill and injectable to expand availability of contraceptive commodities.

ASSESSMENT SCOPE OF WORK

The purpose of the current assignment is to develop a draft strategy for future USAID/Manila support to the WFMC franchise. USAID/Manila wants to ensure a smooth transition of the franchise management from JSI/RTI to the WPFI. The broad objective is to identify and assess areas of focus for future USAID assistance to the WFMC franchise, and to recommend potential strategies for USAID support that will best enhance institutional capability building and promote expansion and financial sustainability of the network in the coming years. The strategy proposed, therefore, should enhance the ability of WFMC franchise to operate and to expand its network in a self-sustaining manner.

The specific objectives of the scope of work include:

1. To assess the status and adequacy of the current WFMC business franchise systems;

2. To review the current WPFI business plan and assess the WPFI's institutional capability vis-à-vis the skills required to manage an effective WFMC business franchise;

3. To assess the network's family planning performance and determine the effectiveness of the WFMC business franchise as a strategy for generating family planning results;

4. To assess the extent of the network's current market penetration and determine potential areas for project expansion; and

5. To identify private sector financing options for future project expansion.

METHODOLOGY

To achieve its purpose, the three person consultant team reviewed documents, conducted interviews with key persons and stakeholders, held focus group discussions with midwives and clients, and visited selected clinics in the National Capital Region and Visayas to gather information on the following:

- USAID's strategic interest in supporting the WFMC franchise;
- Current level of financial sustainability, program success and constituent impact of the current WFMC program strategies, with emphasis on FP;
- Areas of the WFMC franchise that needs strengthening as well as gaps in the management capability of the WPFI in effectively operating the WFMC franchise;
- Private sector financing options available for expanding the network of WFMCs;
- Mechanisms available to USAID for providing future support in the strengthening and expansion of the WFMC franchise network; and
- Definition of a clear timeline and responsibility areas for WPFI and the JSI/RTI in the transition period.

II. CURRENT STATUS (CLINIC PROFILE)

Currently, there are 210 clinics in various levels of development, nationally. Records show that 189 clinics show profit from operations. (Table VI: Sales and Operating Cost Performance. Clinics that did not realize any profit were 2 clinics from page 3, 7 clinics from page 4, and 12 clinics from page 5 for 21 clinics. Out of 210 clinics, therefore, 189 realized profit from operation.) One hundred fifty four clinics indicated gross annual operating revenue of over P25,000 (Table VI: Sales and Operating Cost Performance. The following clinics reported over PHP 25,000 operating profit: 36 clinics from page 1, 42 clinics from page 2, 39 clinics from page 3, twenty clinics from page 4, and 17 clinics from page 5.) and sixty-five clinics registered gross monthly revenue of over P25,000. Over 140 clinics are generating annual gross revenue of over P100,000. This level of performance is commendable in view of the fact that over 25% of these clinics (fifty four clinics) were opened in 2002.

While it is difficult to ascertain the true level of profitability in the absence of the individual clinic audited financial statements, the large number of clinics realizing profits and the size of the profits generated by some of the well established clinics provide strong evidence that the WPMC clinics are viable business enterprises.

Revenues from deliveries performed largely provide the core business of the WF clinics. This represents over fifty percent of the total revenues generated. For example, in the NCR region, over 53% of the clinic revenues were derived from delivery fees alone. Similar average is seen in Region VII and Region XII. Clinics in Region XII and Expanded ARMM generate 47% of their total revenues from deliveries. (Table V-A: Summary of WFMC Gross Revenue Performance, Col. 1) Revenues derived from other business ranks second to delivery. This includes revenues derived from sale of OTC supplies including drugs. The role of family planning services provision in overall revenue generation is not clear since many midwives include a postpartum/family planning visit in their flat fee for a delivery. Thus, this initial family planning service is "hidden" in revenues reported for deliveries. The 5-7% that is sometimes stated as the contribution of family planning services to total clinic revenues is likely, therefore, understated or at least somewhat misleading. Midwives indicated that many clients are provided with either a temporary or long term family planning method after delivery.

Of the total 210 clinics that are now in operation, 56 were started in 1997-98, 58 in 1999-2000, and 89 in 2001-2002. There are currently 21 new WF clinics scheduled to open in 2003. Construction/renovation of these proposed clinics has started and are expected to be completed by the end of June this year. Of the total 210 WF clinics, only 18 are NGO-owned while the rest are owned and operated by midwives.

The majority of the clinics (57) are located in the NCR and Region IV, representing 27% of total (Table 1, Column 3), while Region XII (Central Mindanao) accounts for 14%. Except for Regions II, V, and IX, WF clinics are widely dispersed nationally. Site selection was aided by RMA studies that validated the strategic clinic site locations. Currently, there are nine NGOs, namely: IMCH, NORFI, IMCCSDI, FORFIL, HFC, CFPOI, DMSF-CERDH, COMDEV, LEFADO, and KFI involved in the management and supervision of WF clinics. IMCH in the

National Capital Region monitors the most number of clinics (56), while COMDEV, IMCCSDI and DMSF-CERDH operate/monitor at least 25 WF clinics each.

The WFMC clinics serve largely the C and D clients in the neighborhood where they are located. Most of the clients are working class women who can afford and are willing to pay for the perceived higher quality services. The average delivery fees charged by clinics ranges from P3,000 to P3,500 which is often inclusive of pre-natal visits, post natal check-up, and the initial family planning supply and service. (Some midwives, however, charge separately for pre-natal visits -- P50 to P100 per visit.) Some midwives often include immunization services to make their services even more attractive to clients.

The current WFMC pricing strategy provides an affordable option to many. Provincial and district hospitals currently charge P1,000 per delivery, not including pre-natal and postnatal visits. Private hospitals charge upwards of P16,000. The WFMC clinics are not only serving an essential mid-priced market niche but are also serving a market that has sufficient room for growth and expansion.

Most of the clients of the WFMC clinics are either repeat clients or close associates of satisfied clients served by the clinics. Clients indicated that they were very satisfied with the services performed and will not hesitate to return in the future.

The project has provided midwives with the basic training required in operating the WF clinic. This training includes the following: 1) Basic Comprehensive MW and FP Training; 2) Interpersonal Communication Skills; 3) Family Planning Counseling; 4) Ambulatory Health Facility Management; 5) Suturing Perineal Laceration and Intravenous Insertion; 6) Obstetric Emergencies; 7) Reporting and Monitoring Systems/Bookkeeping; and 8) Clinic Business Planning. The cost of implementing this training program is estimated at P94,300 (assuming 15 participants per training course). All the 210 midwives operators have completed these training courses. The project has also provided each WF clinic with all the equipment/instruments required in providing MCH and FP services. The cost of this equipment is approximately P146,000 per clinic supplied. The equipment and instruments provided include both US-sourced equipment and locally fabricated equipment pre-qualified to meet quality standards.

WF clinic midwives interviewed indicated that their investment for clinic renovation is the most expensive cost component of their WF business. Expenditures on renovations range from P100,000 to P150,000 to comply with WF-required standards. These funds were largely obtained from personal and informal sources. While midwives have indicated their need for additional capital for expansion, particularly to meet the new DOH certification regulations, almost no midwife has availed of commercial loans for her capital needs. Many do not know where they can obtain loans and are not familiar with the application process. In addition, many cannot yet meet the requirements of a bank loan. For midwives who do not own their clinics, rent and utilities represent the highest recurrent costs.

Most midwives find financial management and marketing among the most difficult areas in their business operation. While all have undergone project training in business planning and are maintaining the prescribed financial records, many still indicated that they want additional

training in business management. Chart of accounts are not routinely used in recording both revenues and expenses. In addition, cost of loans, depreciation expenses, and sometimes their own salaries are not accurately included among operating expenses. There are also instances in which other personal expenses unrelated to the business are included in clinic profit and loss statements.

Tables I - VII, included in the Annexes, illustrate the number and location of existing WF clinics, estimated costs of midwife training, necessary clinic equipment and costs, estimated costs of new clinic construction, clinic gross revenues, sales and operational costs performance of each existing clinic, and estimated start-up costs for a new clinic.

III. ASSESSMENT OF FRANCHISE PROSPECTS

FRANCHISE DEVELOPMENT AND MANAGEMENT

The Well-Family Midwife Clinics Partnerships Foundation, Inc., (WFPI) was established to take over the functions performed by the JSI/RTI TANGO project and to serve as the nucleus organization serving the needs of more than 200 midwife clinic managers in the WFMC franchise network. This section focuses on the consulting team's findings and recommendations relative to the feasibility of the WFPI franchise strategy for long-term viability and sustainability.

Core Partnership

Finding

There is no COO/Executive Director in place to provide leadership and momentum to WFPI and franchise development activities.

Recommendation

- Hire an appropriately qualified Executive Director as soon as possible.

Finding

Business/commercial expertise necessary for directing a complex franchise operation is not adequately represented in the current constitution of the Board of Directors.

Recommendation

- Strengthen the composition of the partnership's Board of Directors by adding a significant number of commercial/business members. These commercial members could include individuals such as operators/managers of private sector healthcare companies, managers/owners of successful franchise companies in the Philippines, and representatives from the commercial banking sector.

Finding

The six-year horizon for break-even projected in the WFPI business plan far exceeds commercially acceptable standards (three years) for new business sustainability.

Recommendation

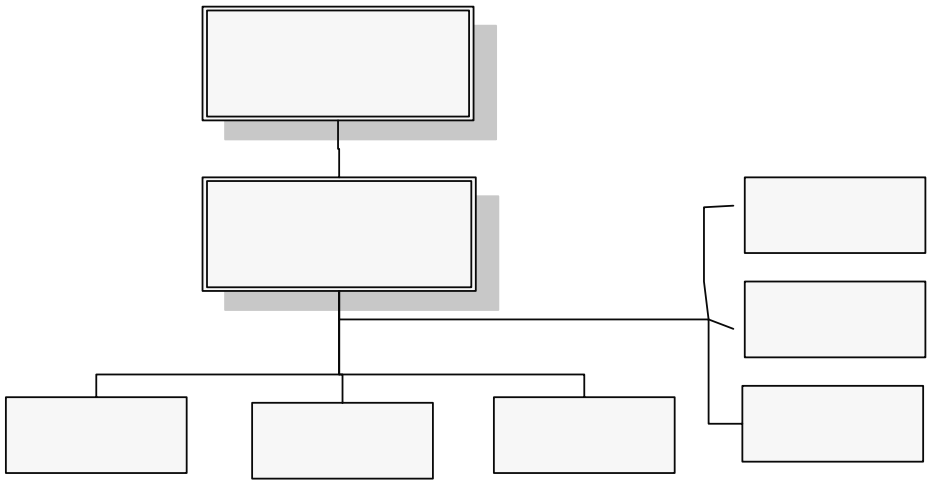
- Recast current WFPI business and financial projections on the basis of a three-year horizon for break-even.

Finding

Costs of the foundation projected in the current business plan appear high -- i.e. number of staff, equipment to be purchased, etc.

Recommendations

- Develop and describe clearly and specifically the role of the foundation/partnership in the overall franchise system. This role could include:
    - development of franchise policy and service delivery standards
    - ownership of the brand (standards and marketing)
    - overall franchise/brand management
    - annual/semi-annual standards/performance audits
- Outsource clinic level supervision, midwife training, and other technical assistance.



- Give at least as much importance in foundation/partnership financial planning and projections to cutting costs of the foundation/partnership as to increasing volume of fees collected.

- Further partnership expenditures for equipment and office furniture should be largely deferred until after December 31, 2004, when TANGO Project equipment and furniture will likely revert to USAID and could, perhaps, be transferred at little or no cost to the partnership.

Franchise Clinic System

Finding

The number of years (six) currently projected in the partnership business plan for break-even is outside generally accepted commercial parameters (three).

Recommendation

- Develop a foundation/partnership financial plan for breaking even by the end of the third year of operation.

Finding

All operational systems, financial systems, and manuals required for implementation of the commercial franchise system are not yet completed and implemented.

Recommendations

- Complete the development of all operational systems and manuals required for implementation of the franchise system.

- Do not sell/open any new clinics/franchise outlets before January 1, 2005. Get the WF franchise solidly in order first.

Findings

The franchise model (i.e. the financial experience - profitability, costs, timeline - of existing clinics) does not appear to be fully, accurately known.

The franchise model projected by currently estimated clinic start-up costs (P800,000) is significantly different (higher end) from the current WF clinic profile.

Recommendation

- Secure the services of a firm of chartered accountants to assist each existing WF clinic manager in installing and utilizing a uniform chart of accounts and financial statements. The financial system, once established, will facilitate 1) preparation of the franchise's overall financial projections, 2) marketing the franchise as a viable investment

opportunity to potential franchisees, 3) validation of the foundation's sustainability prospects, 4) application of clinic managers for low-cost credit, and 5) monitoring and collection of franchise fees.

Finding

Some fundamental pieces of clinic service delivery and financial data (e.g., number of FP clients/clinic, units of contraceptives sold by method, number of deliveries per clinic per month prior to CY 2002) are either not available or not available in an easy-to-access form.

Recommendation

- Complete a service delivery/financial matrix that includes every existing WF clinic. Include, for example, the number of deliveries per clinic per year, number of family planning clients, number and kind of contraceptive methods distributed, number of immunizations, other services provided, number of months in operation as a WF clinic, and some indication of business growth (and in what areas) over the past year's experience. This clinic-specific matrix should be designed to show the status of the network for any given year or other selected period.

Finding

What the partnership has of value to provide or sell is not yet clearly enough defined from the perspective of the midwife/potential franchise purchaser (as opposed to the perspective of potential donor organizations) and does not seem to be fully understood by existing WF midwives.

Recommendation

- Develop a clear and specific statement of the benefits to midwives/franchisees of the foundation/partnership. This statement should facilitate the willingness of existing midwives to pay royalty, conversion, and other fees, and the willingness of potential franchise investors to pay the proposed franchise fee. The benefits of WFPI participation could include, among others, such things as the following:

    - access to low-cost credit,
    - organization of training opportunities for professional development,
    - group insurance,
    - PhilHeath accreditation,
    - discount/low prices through volume purchasing,
    - technical assistance in business management,
    - technical assistance in local marketing, and
    - overall brand awareness.

Finding

The revenue and image needs of a successful commercial franchise system will require greater or more systematic emphasis on and monitoring of clinic service delivery levels, and rates of business growth than is currently in place.

Recommendation

- Set clear and specific clinic performance standards (including family planning service delivery). State the conditions that will lead to de-selection of consistent under-performers. That is, set up standards and a monitoring/audit system that protect the value of the WF brand and ensure service delivery impact.

Finding

Clinic managers under the existing WF network system will need to be transferred to the new commercial franchise network. This transfer may require the clinic managers to change their expectations as well as performance in some areas of clinic operations and business management.

Recommendations

- The shift from a donor-funded project to a commercial franchise network should be underscored and supported in the minds of clinic managers through a variety of mechanisms. This transition should include at least the setting of clinic-specific goals for business/revenue growth and for growth in number and type of services delivered.

- Develop the first five-year franchise agreement for existing WF clinics, sign the agreements, collect "conversion" fees.

Finding

There is potential for a possible divisive or negative relationship between existing WF midwives and new franchise purchasers because of the widely divergent costs to each group of network participation.

Recommendation

- Develop, through consultation with FranCor and existing clinic managers, an appropriate "conversion fee" (in place of the franchise fee to be charged new franchise purchasers) for existing clinics' transition into the commercial franchise system. Develop a clear and specific statement of what the franchise fee/conversion fee and royalty fees "buy" for franchise holders. Sell the concept of/reason for the conversion fee to existing clinic managers.

Finding

High performance midwives will be especially important to the WFPI during the early days of franchise sales as examples of franchise success to potential purchasers and as sources of fee/royalty revenues for the partnership organization. Two of the highest performing midwives have reportedly resigned from the network with the institution of royalty fees on every (no ceiling) delivery.

Recommendation

- Assess the feasibility of setting a ceiling on royalty fee payments during the first five-year franchise period for existing WF clinics (i.e. assess the value/need of keeping WF high performers in the network versus the revenues that might be lost to the partnership if such a ceiling is implemented. How many midwives would be affected? What should the monthly ceiling be?)

Finding

Many, if not most, existing WF clinics do not meet the recently established DOH requirements (50 sq. meters, separate labor room, two toilets) for accreditation of non-hospital outlets. PhilHeath accreditation requires that each accredited clinic meet DOH standards. Some WF clients interviewed commented that their most desired change in WF clinics is increased space.

Recommendations

- Develop for each existing clinic a list of changes that need to be made to ensure compliance with both WF standards and the newly imposed DOH standards. Ascertain the cost to each clinic of making the required changes.

- Facilitate negotiations between DCA and local lender(s) for low-cost credit available to WF midwives for clinic upgrades. Assist each clinic manager in the preparation of required loan application papers.

Finding

The role of NGOs, namely the role of the partnership, in the commercial franchise system is not clearly developed. The presence of NGO representatives on the Board of Directors may lead in future to conflicts of interest in partnership policy and management decisions.

Recommendation

- Negotiate/develop a clear understanding of the future role of NGOs in the franchise system (especially the role of the foundation/partnership). Resolve the potential conflict of interest between NGOs' role as board members and NGOs' role as potential subcontractors/service providers.

Finding

It appears that many WF midwives currently obtain at least some of their clinic supplies (contraceptives, vaccines, even gloves) free from public sector sources. The supply of free contraceptives from the public sector will almost certainly come to a halt with the cessation of USAID's provision of contraceptive methods to the DOH. Among other ramifications of this current practice is the lack of accuracy of clinic level financial records that purportedly reflect operational costs.

Recommendation

- Develop and implement a system for procurement of low-cost contraceptives and other supplies, especially to prevent contraceptive stockouts within the WF network, but as a possible mechanism for revenue generation by the WFPI or its NGO partners. Evaluate the extent to which clinic managers currently receive (even if informally) free or nearly free supplies of many kinds from public sector sources, and their interest in/need for sources of low-cost products of various types.

Family Planning

Finding

The family planning impact of the Well-Family clinic network is not sufficient to be seen in national CPR data due to the limited number of WF clinics, limited population covered, and scattered clinic locations.

Recommendation

- Establish a system/process/measure for monitoring and evaluating the family planning service delivery of WF clinic operations. Consider, for example, using the number of deliveries provided as a denominator for judging the network's success in converting obstetric clients into family planning clients. Track the number of clients who come into the system first/primarily for FP services. Track continuation/discontinuation of method use among WF clients as well as any method switching that occurs over time.

Finding

The role of family planning services provision in overall revenue generation is not clear since many midwives include a postpartum/family planning visit in the flat fee charged for a delivery. Thus, this initial family planning service is "hidden" in revenues reported for deliveries. The 5-7% that is sometimes stated as the contribution of family planning services to total clinic revenues is likely, therefore, understated or at least somewhat misleading.

Recommendations

- The WFPI should develop a plan for institutionalizing family planning in its franchise scheme, and for monitoring the continuation of family planning services delivery by its franchisees since FP service delivery is not a predominant source of revenue for clinic operators and might, therefore, be ignored or slighted in clinic operations over time.

- The partnership should develop a marketing package specifically designed for increasing the importance of family planning to WF clinic business by increasing the number of family planning clients served, the conversion rate of obstetric clients to family planning clients, and the number of contraceptive units sold by WF clinic midwives. Technical assistance should be provided to each midwife in institutionalizing FP marketing strategies into her business operations, and the growth in FP business in each clinic should be monitored by the partnership.

Finding

Data are not available on the number of family planning acceptors/clients served and the units of contraceptives sold through the WF clinic system.

Recommendation

- Develop and institutionalize a FP reporting system that will provide the data necessary for WFPI to monitor the network's overall FP impact, will be easy for midwife managers to implement, will facilitate midwives' management of their own business growth, and will allow accurate WFPI analysis of clinic FP performance.

Finding

The Well-Family midwife clinic network was designed to be an outlet for efficient and effective provision of family planning and maternal and child health care services. Moreover, one of the objectives of the WFPI is to highlight the private sector's initiative and contribution in serving previously unmet needs for family planning and as an alternative facility for affordable maternal and child health services. Family planning services, however, generate a significantly lower level of revenues than delivery services in WF midwife clinics. Efforts in providing and increasing family planning services, therefore, might not be given emphasis or attention over time due to the competition from more lucrative services.

Recommendation

- Support for family planning and willingness to proactively offer family planning services should be one of the primary selection criteria for potential WF franchisees. Unless WF midwives are committed to advocacy for family planning, the overall impact on family planning acceptance of the WF network may not be optimal. An acceptable level of business growth in family planning services delivery should be one of the criteria used to judge the success of each WF clinic/franchisee and as a criterion for franchise retention.

Finding

Mass media marketing of family planning in general is outside the service delivery scope and financial resources of the Well-Family clinic business.

Recommendation

- Resources available for WF marketing related to family planning acceptance and use should be concentrated on the clinic/community level and should be tied in directly to the midwife's community outreach and home visit activities, and to her clinic counseling.

FINANCIAL MANAGEMENT

Finding

The six-year horizon for break-even projected in the WFPI business plan far exceeds commercially acceptable standards (three years) for new business sustainability.

Recommendation

- Recast current WFPI business and financial projections on the basis of a three-year horizon for break-even.

Finding

Costs of the foundation projected in the current business plan appear high -- i.e. number of staff, equipment to be purchased, etc.

Recommendations

- Give at least as much importance in foundation/partnership financial planning and projections to cutting costs of the foundation/partnership as to increasing volume of fees collected.

- Further partnership expenditures for equipment and office furniture should be largely deferred until after December 31, 2004, when TANGO Project equipment and furniture will likely revert to USAID and could, perhaps, be transferred at little or no cost to the partnership.

Finding

The franchise model (i.e. the financial experience - profitability, costs, timeline - of existing clinics) does not appear to be fully, accurately known.

Recommendation

- Secure the services of a firm of chartered accountants to assist each existing WF clinic manager in installing and utilizing a uniform chart of accounts and financial statements. The financial system, once established, will facilitate 1) preparation of the franchise's overall financial projections, 2) marketing the franchise as a viable investment opportunity to potential franchisees, 3) validation of the foundation's sustainability prospects, 4) application of clinic managers for low-cost credit, and 5) monitoring and collection of franchise fees.

Finding

Many/most midwives do not appear to have an accurate concept of clinic costs (i.e. they may include personal expenses in clinic costs and may not include costs of credit/investment and depreciation).

Recommendation

- Develop and implement standardized financial systems for clinic management and reporting. Provide technical assistance to each midwife in setting up and using these standard systems as well as follow-up training/ workshops in using the systems for clinic business management and financial success.

RESOURCE GENERATION AND MOBILIZATION

Finding

Almost every WF midwife is obtaining some necessary supplies (gloves, vaccines, contraceptives) free from CHO, RHU, or other government facility.

Recommendation

- Explore the feasibility of procuring low-cost supplies and products for re-sale to franchisees as a mechanism for generating worthwhile levels of revenue for the partnership's sustainability.

Finding

Local lender(s) have interest in lending to midwives, especially with DCA backing.

Recommendations

- Continue to pursue with DCA representatives the availability of low-cost credit from local, commercial sector lenders.

- Although DCA backing is not possible for WF midwife loans that might be made by the Small Business Group (because of public sector participation in its governance), it may still be possible to access low-cost loans from this funding source for WF midwives. The feasibility/process of loan application involving this financial entity should continue to be explored and pursued by JSI staff on behalf of the WFPI and its member midwives.

Finding

Virtually all Well-Family midwife clinics are outside the new requirements for DOH certification and will need low-cost credit to be able to remodel to meet the requirements.

Recommendation

- Provide technical assistance to member midwives in establishing and implementing necessary financial systems, generating required financial reports, and in completing required applications for low-cost loans for clinic expansions and upgrades.

Finding

The almost complete financial dependence of the WFPI on the payment of royalty and franchise fees by participating midwives leaves the partnership unduly vulnerable to anything in the environment that might have negative impact on its narrow resource base and could, therefore, limit the partnership's prospects for long-term sustainability.

Recommendations

- The consulting team concurs with FranCorp's suggestion that the WFPI explore the feasibility of developing and operating a limited number (perhaps up to five) of "company-owned" WF clinics. Three purposes could be served by these clinics: 1) They would provide model clinic sites that the partnership could display in the process of marketing franchises to potential franchise purchasers. 2) These clinics would provide company-controlled sites for testing best/new clinical practices as well as clinic level marketing strategies before rollout through the whole WF system. 3) Perhaps most importantly, these clinics if well managed could provide through their profits long-term funding support to the WFPI.

Profitability considerations would seem to dictate that any partnership-owned clinics be located in areas where the population is mostly likely to accept and utilize a WF clinic, have the money to pay for services, and where the clinics could be easily reached by WFPI staff for management and supervision. Such areas would include the NCR but not under-served rural areas of low population density or lower ability to pay.

Before any decision is made concerning investment in partnership-owned clinics, detailed financial projections should be developed and carefully analyzed. WFPI should enlist the services of FranCorp and a firm of chartered accountants in developing and analyzing these projections that should include all possible costs related to WFPI's ownership and operation. Moving ahead with such an investment should occur only if the projections show great likelihood of substantial returns/profitability.

The ability of the WFPI to develop and initiate company-owned clinic operations will be limited by its ability to fund clinic start-up costs. The consulting team has considered two possible mechanisms for the partnership's early access to start-up funds. First, USAID might choose to provide limited, longer-term support to WFPI in the form of funds for initial capital investment in a specified number of clinics. Profits from operating the clinic(s) would continue to support the WFPI throughout time. The team estimates that the initial capital investment required per clinic should not likely exceed US$15,000. Second, the WFPI could borrow, through a DCA-backed loan from a local lender, the US$15,000 necessary for new clinic start-up -- just as individual midwives/franchise purchasers will be expected to do.

If this course of action is pursued, the team believes that the partnership should undertake the development and opening of one clinic at a time. Not only does this phased approached allow for sufficient management attention to ensure greatest possible clinic success but also minimizes the financial risk involved by allowing time to demonstrate the real feasibility/profitability of this strategy in generating funds for WFPI before making additional investments. Additionally, the ownership and operation of one successful clinic increases the credit-worthiness of WFPI with local lenders who may be needed for other funds.

- Some related business, other than a partnership-owned clinic, might also broaden the partnership's revenue base and thus decrease its financial vulnerability. Such a related business might be the ownership/operation of a laboratory to process Pap smears, blood work, etc. for WF midwives at a preferential but still profitable rate and for non-network midwives/physicians at a commercial rate. The feasibility and profitability prospects of such an enterprise would need to be closely studied and realistically estimated before investment in its implementation.

- The WFPI may need to explore other creative and innovative strategies for resource generation and mobilization to increase its capital funds for both development and business tasks and to increase client reach. Joint ventures might be established with LGUs who are genuinely interested in improving FP and MCH services and in de-clogging public health facilities but who are constrained by " socio-political" factors. Support from LGUs may come in various forms such as provision of clinic space for free or low rental fees, allocation of funds for clinic renovation, and support to ensure the integration of WFMCs in the referral system of the Inter-Local Health Zones. This strategy might increase private sector participation at the local level and stimulate community advocacy for improved FP and MCH services.

- Another strategy for resource generation and mobilization to be explored is the possible establishment of institutional partnerships with training or academic institutions that have outreach programs in order to mobilize as a resource a pool of FP trainers, facilitators, researchers, and business consultants. This strategy could support partnership NGOs in

expanding their resource pool and decreasing costs of professional fees for capacity building programs.

- The foundation may be able to leverage resources generated from the LGUs and private sector with USAID or other funding institutions for capital build-up.

MARKETING

Findings

Revenues derived from performing delivery services provide the largest contribution to WF clinic total revenues. For instance, in the NCR region in 2002, revenue from deliveries represents over 53% of total revenue. A similar profile is observed in Regions VII and XII. Clinics in Region XII and Expanded ARMM generate 47% of their total revenues from deliveries. (Table V-A: Summary of WFMC Gross Revenue Performance, Col. 1) On average, the majority of WF clinics perform 9-10 deliveries a month, or 90-120 deliveries a year. The majority of current service delivery fees appear to range from P3,000-P3,500 and represent the major component of total gross revenues. Average utilization of WF clinic capacity for delivery services, however, is estimated in JSI documents as only about 50%. Without motivation and marketing skills in expanding client reach, WFMCs may not reach break-even points and may be de-selected for low performance. This may be a critical concern and risk for the foundation where royalty fees of the midwives contribute to the foundation's generation of funds to support its own operating costs.

Severe overcrowding in obstetric wards seen in public sector hospitals demonstrates yet untapped market potential. Many WF clinics within the vicinity of a district/provincial hospital are not getting a reasonable share of the "overflow" deliveries performed in these often overcrowded institutions. This circumstance seems to indicate that there is insufficient attraction for obstetric clients to seek out the services of WF clinics.

It is important to note that many LGUs are improving health service facilities through the DOH Sentrong Sigla Movement (Seal of Quality Assurance) and implementation of health sector reforms. Some government hospitals have provided improved facilities for fee-based services for clients (from the targeted C and D segments) who are willing to pay. Some clients have expressed more confidence in going to hospitals for professional care by doctors and nurses than in going to the clinics of midwives.

Performance of WF clinics depends largely on the aggressiveness and interpersonal relationships of the midwife. Strategic location of the clinic, while important, seems secondary to the personal service the midwife is perceived by clients to provide. The personal relationship between midwife and client (trust, TLC, personal attention made possible by lack of crowding) is the unique selling proposition of WF clinics for many/most satisfied clients.

Most midwives say most of their new clients come from previous/satisfied client referrals. Some midwives indicate that some new clients come to them through referrals from neighboring RHUs -- especially in those cases where the WF midwife has a personal or previous professional relationship with the midwife(s) at the referring RHU.

While delivery services represent the core business of the WF clinic, it is observed that marketing strategies on a per clinic basis are not consistently well developed or implemented. Currently, midwives may promote their clinics in various innovative ways to attract clients. This practice may create different perceptions of the WFMC franchise product or brand.

Recommendations

- Strengthen and improve internal marketing at the clinic level. There is a need to develop an expanded package of clinic level marketing activities that supports the existing word of mouth marketing and that becomes a part of the franchise system. There is also a need to develop and disseminate through some appropriate channel, a standard list of all the marketing "tricks of the trade" currently used successfully by midwives to increase their business -- for example, commissions to other providers (RHU, hospitals, BHW, etc) for referrals; discounts to existing clients for referring new clients; barangay meetings; etc. -- in addition to existing strategies already in place. The competitive advantages of WF clinics need to be more aggressively and systematically marketed.

- Increase and systematize efforts for collaboration and coordination between the WFMCs and rural health centers so that those women who can afford, and those who want prompt service for FP/MCH are routinely referred to WF clinics that are open twenty-four hours daily. These referrals would also serve to reduce the number of users of public health facilities with their limited resources and staff.

- Set business growth and service delivery goals with each participating midwife and regularly monitor for her clinic's performance toward achievement of those goals. Create peer partnerships or mentoring relationships among WF midwives that counsel and encourage the consistent implementation of marketing activities and achievement of business and service delivery growth goals. Provide "remedial" marketing assistance to those midwives who are not moving steadily toward achievement of their annual goals. Clearly define acceptable levels of business and service delivery growth and make achievement of those levels a condition of franchise retention.

- Explore through appropriate research mechanisms the existing and future possible value of the Well-family name/brand in attracting new clients to network clinics for delivery and other services.

Finding

Family planning services represent a considerably smaller contribution to each clinic's total revenues than do deliveries. However, many WF family planning clients require contraceptive products and/or services regularly throughout the year. On the other hand, the number of deliveries per month at each clinic is reported by many midwives to vary widely and even to be seasonal.

Recommendation

- Marketing of family planning services represents an opportunity for WF midwives to smooth out some of the variations in their monthly income from deliveries by increasing the number of clients who come regularly to their clinics for other services. This value to their businesses of marketing family planning services and products should be discussed and promoted among participating midwives.

RISK ASSESSMENT

While there are many evidences of the feasibility of the WF clinic network and indications of the likelihood of its commercial and long-term sustainable success, there are -- as with any new business start-up -- elements of risk in the undertaking. The consultant team has identified the following areas as risks of particular importance and worthy of special consideration, planning, and monitoring:

- Midwife owner profile implied by projected start-up costs (higher end), profile of current clinic managers;
- Drop-out/turnover rates among midwives during transition to commercial franchise system;
- Inability to validate current feasibility studies and financial projections;
- Currently projected costs of partnership, expected revenues;
- Partnership's limited sources of revenues highly dependent on systematic collection of fees;
- Long-term status of family planning in service delivery strategy;
- Success heavily dependent on the personality of selected midwives;
- Tension between commercial and social agendas especially in site selection process; and
- Dedication and leadership of COO/Executive Director; quality of governance.

IV. PROPOSED STRATEGIC DIRECTIONS FOR USAID SUPPORT

The consulting team believes that WFPI will require some level of external support through CY2006 if the commercially accepted break-even horizon of three years is used.

The consulting team believes that continued USAID support for the next three years is essential to achieve the sustainability goals of the foundation particularly the preparation for the transition of the existing clinic network into commercially viable franchise units. This support should include at least the following: 1) for JSI – to continue its role during the next eighteen months in facilitating this transition; 2) for FranCorp – to provide over the three-year period technical assistance and supervision to support the full development of both the existing clinic network and the new franchise clinics into completely viable commercial enterprises; 3) for an auditing/accounting agency – to develop and install a standardized accounting system that will serve as the basis for financial projections and financial monitoring/royalties collection; and 4) for a contribution to a capital pool from which franchise clinics can draw start-up capital and/or building expansion needs.

USAID funding after December 2004 should be contingent upon the WFPI's achievement of mutually agreed upon business and/or service delivery goals.

Given a well designed and implemented transition plan, the team believes that the majority of the existing clinic network can be transformed into viable and sustainable business enterprises.

From now through December 31, 2004, USAID funding support for WF-related activities can be funneled through its cooperative agreement with JSI. The mechanism available for USAID funding support from January 1, 2005, until December 31, 2006 is not so clear, to the extent that current USAID regulations require local grant/cooperative agreement recipients to have a three year track record and audited financial statements; but perhaps a mechanism for providing necessary funding directly to WFPI can be approved.

USAID may also wish to provide some type of limited, longer term (post 2006) assistance to WFPI in view of the reproductive health/social development agenda of the partnership. Such longer term, though limited, funding involvement might also provide USAID with continuing leverage on partnership policy and service delivery priorities.

Several possible mechanisms are available to USAID for longer term, limited funding:

- creation of an endowment;
- capital investment in a designated number of partnership-owned WF clinics;
- DCA backing for low-cost loans to the partnership; and
- DCA-backed loan trust.

ENDOWMENT

Creation of an endowment, the interest from which could be used by the partnership for operational or other costs, is the future funding mechanism that gives USAID perhaps the best opportunity for future leverage on WF partnership policy and service delivery priorities. Considerations in creation and use of endowment funds could include at least the following elements:

- Interest should accumulate for at least three years before release of any funds;
- Only interest income generated should be released for use;
- Performance benchmarks should be considered/established as the basis for release of interest income generated;
- A qualified securities management firm should be contracted to manage the portfolio with an agreed upon minimum rate of return;
- An accounting firm should be contracted to conduct regular audits and issue audit reports;
- A founding agreement should be written between USAID and WFPI that clearly specifies the life of the endowment, allowable uses of the funds generated by the endowment, the composition of the endowment's Board of Trustees, and the fiduciary responsibilities of the Board of Trustees.

An example of the approximate level of funds that could be generated over time by the investment of a US $1,000,000 endowment at a rate of 5% per annum is shown below:

Year	Principal	Interest	Total
End Year 1	1,000,000	50,000	1,050,000
End Year 2	1,050,000	52,500	1,102,500
End Year 3	1,102,500	55,125	1,157,625

An additional benefit of an endowment to WFPI is that an endowment can be used as collateral in securing a loan from a commercial bank. Since WFPI does not yet own any clinic facilities, it currently has nothing to offer as collateral should it ever wish to obtain a loan. The longer-term sustainability prospects that an endowment implies may also be useful to WFPI in making it a more attractive potential partner to other private/ commercial sector entities in creating new business opportunities or completing new business deals.

CAPITAL INVESTMENT IN PARTNERSHIP-OWNED CLINICS

The almost complete financial dependence of the WFPI on the payment of royalty and franchise fees by participating midwives leaves the partnership vulnerable to anything in the environment that might have negative impact on its narrow resource base and could, therefore, limit the partnership's prospects for long term sustainability.

To offset this potential vulnerability, the WFPI could explore the feasibility of developing and operating a limited number of "company-owned" WF clinics. These clinics if well managed could provide through their profits long-term funding support to the WFPI. USAID might choose to provide limited, longer-term support to WFPI in the form of funds for initial capital investment in a specified number of clinics. Profits from operating the clinic(s) would continue to support the WFPI throughout time. The team estimates that the initial capital investment required per clinic should not likely exceed US$15,000.

A phased approach to USAID provision of funds for initial capital investment in partnership-owned clinics could accommodate use of prerequisites for each new clinic funded. In other words, funding for the first partnership-owned clinic might become available after the achievement of mutually agreed upon benchmarks related to royalty collections, franchise sales, or services delivered. Funding for a second clinic could then come after the achievement of another set of benchmarks and so forth.

DCA BACKED, LOW COST LOANS AND LOAN TRUST

These options for low cost credit and profit from lending were being explored and developed during the time of the consultant team's visit by a representative from the DCA. It is expected that the report prepared by the DCA consultant will describe these options in detail.

V. TIMELINE FOR USAID SUPPORT

A. Three years' support definitely required (CY 2004, 2005, 2006)

-Present to end of CY 2004
- Mechanism
  - Through JSI
- Types of support
  - Technical assistance (FranCorp, CPAs, JSI, NGOs)
  - Limited operational costs

- CY 2005
  - Prerequisites for support
    - Institutionalization of standardized financial systems down to the clinic level
    - Reformulated partnership business and financial plans (leaner partnership, verifiable financial data)
    - Completed franchise systems, manuals, marketing plan
  - Mechanism
    - Uncertain due to USAID regulations regarding local grant/cooperative assistance recipients
  - Types of support
    - Technical assistance (FranCorp, CPAs, others?)
    - Percentage of operating costs tied to level of partnership's fee and royalty collections

- CY 2006
  - Prerequisites for support
    - Completion of agreed upon number of franchise sales
    - Retention of agreed upon percentage of "original" WF midwives in commercial franchise system
  - Mechanism
    - As for CY 2005
  - Types of support
    - Technical assistance as required
    - Reduced level of support for operating costs tied to franchise performance

B. After CY 2006
- Rationale
  - Leverage on franchise policy and service delivery priorities
- Options
  - Endowment
  - DCA-backed trust
  - Capital investment in partnership-operated, revenue generating clinics

ANNEXES

Annex A

OUTLINE FOR USAID DEBRIEFING, MAY 7, 2007

PROPOSED STRATEGY FOR FUTURE USAID SUPPORT TO THE WELL-FAMILY MIDWIFE CLINIC FRANCHISE NETWORK

I. Scope of Work

- To assess the status and adequacy of the current WFMC business franchise systems;
- To review the current WPFI business plan and assess the WPFI's institutional capability vis-à-vis the skills required to manage an effective WFMC business franchise;
- To assess the network's family planning performance and determine the effectiveness of the WFMC business franchise as a strategy for generating family planning results;
- To assess the extent of the network's current market penetration and determine potential areas for project expansion; and
- To identify private sector financing options for future project expansion.

II. Accomplishments of the WFMC Network

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- Over 210 WF clinics have been established and are operational. 190 show profit from operations. Over 140 have gross annual revenue of P100,000 derived largely from delivery fees
- WFMC model is a successful private sector initiative that complements public sector services.
- WFMC clinics have national coverage (11 regions) in MCH and FP services delivery
- All WF midwife clinic managers have completed 11 training programs provided by the project.
- The WFPI has been established, legally registered, and board members have been selected.
- The development of WFPI marketing and financial plans has been initiated with technical assistance.
- Successful WFMC midwives have elevated the status of the profession in their communities and regions.
- WF midwife clinics attending to over 32,000 births/year have provided a viable alternative to the public sector for women who are capable and willing to pay for delivery services.
- WF midwife clinics have contributed to decongestion of public sector obstetric facilities.

III. Sources Providing Basis of our Assessment

A. Feasibility study (De La Salle)
B. Financial study
C. Business plan

D. Personal interviews with WFPI Board Members, USAID/PHN staff, JSI project staff, DCA representative, midwives, WF clinic clients, private lending organizations, FranCorp representatives, regional IMAP staff, PhilHealth representatives
E. JSI/RTI project reports and documents

IV. Future Directions

A. Horizon for break-even (3 years)

B. Reaching break-even
- Leadership (COO and Board of Directors)
- Institutionalization of standardized financial systems
- Cutting costs
    - Staffing and outsourcing
    - Furniture and equipment
- Maximizing revenues from existing clinics
    - Systematic royalty fee collection
    - Conversion fees
    - Marketing: growth in business of existing clinics
        - Larger market exists (deliveries and FP)
        - Clinic capacity exists
        - Expansion of clinic/community level marketing
- Solidification of franchise concepts, systems, marketing packages
    - Institutionalize standardized financial systems down to the clinic level
    - Clarify (from clinic managers' point of view) value of partnership and WF franchise
- Exploration of feasibility of partnership-operated WF clinic(s) as generator of revenues for partnership support and laboratory for best practices
    - Maintaining focus on franchise development and sound systems
    - Delay sale of new franchises until 1 January 2005
- Exploration of feasibility of joint ventures with LGUs and other institutions

V. Proposed Strategy for USAID Support

A. Three years' support definitely required (CY 2004, 2005, 2006)
- Present to end of CY 2004
    - Mechanism
        - Through JSI
    - Types of support
        - Technical assistance (FranCorp, CPAs, JSI, NGOs)
        - Limited operational costs
- CY 2005

- Prerequisites for support
    - Institutionalization of standardized financial systems down to the clinic level
    - Reformulated partnership business and financial plans (leaner partnership, verifiable financial data)
    - Completed franchise systems, manuals, marketing plan
- Mechanism
    - Uncertain due to USAID regulations regarding local grant/cooperative assistance recipients
- Types of support
    - Technical assistance (FranCorp, CPAs, others?)
    - Percentage of operating costs tied to level of partnership's fee and royalty collections

- CY 2006
    - Prerequisites for support
        - Completion of agreed upon number of franchise sales
        - Retention of agreed upon percentage of "original" WF midwives in commercial franchise system
    - Mechanism
        - As for CY 2005
    - Types of support
        - Technical assistance as required
        - Reduced level of support for operating costs tied to franchise performance

B. After CY 2006
- Rationale
    - Leverage on franchise policy and service delivery priorities
- Options
    - Endowment
    - DCA-backed trust
    - Capital investment in partnership-operated, revenue generating clinics

VI. Risk Assessment

- Midwife owner profile implied by projected start-up costs viz. profile of current clinic managers
- Drop-out/turnover rates during transition to commercial franchise system
- Inability to validate current feasibility studies and financial projections
- Currently projected costs of partnership viz. expected revenues
- Limited sources of revenues highly dependent on systematic collection of fees
- Long-term status of family planning in service delivery strategy
- Success heavily dependent on "personality" of selected midwives
- Tension between commercial and social agendas especially in site selection process

Annex B

TASKS RELATED TO INITIATION OF WELL-FAMILY CLINIC FRANCHISE SYSTEM: JUNE 2003 THROUGH DECEMBER 2004

TASKS RELATED TO INITIATION OF WELL-FAMILY CLINIC FRANCHISE SYSTEM: JUNE 2003 THROUGH DECEMBER 2004

A. Franchise Development and Management

1. Core Partnership/Foundation

- Hire appropriate qualified Executive Director/CEO.

- Strengthen the composition of the foundation/partnership Board of Directors by adding a significant number of commercial/business members.

- Develop or modify the existing staffing and operational plan for the foundation/partnership in order to cut costs -- i.e. explore out-sourcing wherever possible.

2. Franchise/Clinic System

- Complete service delivery/financial matrix that includes every existing clinic.

- Develop for each existing clinic a list of changes that need to be made to ensure compliance with both WF standards and the newly imposed DOH standards. Ascertain the cost to each clinic of making the required changes.

- Complete the development of all operational systems and manuals required for implementation of the franchise system.

- Develop, based on the picture gained from the clinic level financial statements and balance sheets, a clear and specific statement of what the franchise "product" is as well as of realistic expectations for potential franchisees of their return on investment and timetable for cost-recovery and profitability.

- Negotiate/develop a clear understanding of the future role of NGOs in the franchise system (especially viz. the role of the foundation/partnership). Resolve the potential conflict of interest between NGO role as board members and NGO role as subcontractors/service providers.

- Develop through consultation with Francor and existing clinic managers an appropriate "conversion fee" (in place of the franchise fee to be charged

new franchise purchasers) for existing clinics' transition into the commercial franchise system.

- Sell concept/reason for conversion fee to existing clinic managers.

- Develop the first five-year franchise agreement for existing WF clinics, sign agreements; collect conversion fees.

- Develop a clear and specific statement of what the franchise fee/conversion fee and royalty fees "buy" for franchise holders.

- Develop and implement a system for procurement of low-cost contraceptives and other supplies. Evaluate the extent to which clinic managers currently receive (even if informally) free or nearly free supplies of many kinds from public sector sources.

- Assess the feasibility of setting a ceiling on royalty fee payments during the 1st five-year franchise period for existing WF clinics (I.e. assess the value/need of keeping WF high performers versus revenues that might be lost. How many midwives would be affected? What should the monthly ceiling be? 25 deliveries? 30 deliveries? Develop various revenue scenarios.)

- Set clear and specific clinic performance standards. State the conditions that will lead to deselection of consistent under-performers. (I.e. set up standards and monitoring/audit system that protect the value of the WF brand and ensure service delivery impact.)

- Establish system/process/measure for monitoring and evaluating the family planning impact of WF clinic operations. (Use the number of deliveries as a denominator?)

B. Financial Management

- Provide technical assistance to every midwife in preparing a financial statement and balance sheet for each existing WF clinic as first step in development of clinic level financial systems.

- Develop and deliver to all midwives training in use of the clinic level financial systems (including training in the benefits to themselves of these systems as well as in how to use the systems for improved management of their businesses).

- Develop a system for collection of clinic financial data and royalty fees including a system for monitoring to ensure appropriate payments.

- Develop a business plan that demonstrates break-even for the foundation/partnership by the end of the third year.

C. Resource Generation and Mobilization

- Complete the development of a low-cost lending scheme and the negotiations between DCA and local lender(s) that make the scheme possible.

- Provide the assistance necessary to each qualifying clinic manager for low-cost loan application under the WF developed scheme.

- Complete the process of PhilHealth accreditation for those clinic managers who want it.

- Assess the feasibility of partnership/foundation-owned clinics as generators of profits that can be used to support partnership/foundation costs.

D. Marketing

- Complete development of the WF franchise sales "package." The package should include at least the following:

  - "model"/successful clinics to show to potential franchise buyers
  - solid financial estimates and realistic projections of initial investment costs and rate of return on investment
  - low-cost credit availability
  - standard clinic description
  - standard equipment description
  - training requirements
  - marketing support available
  - performance standards and expectations ("deselection" process)

- Strengthen and improve internal marketing at the clinic level. (Most new clients of the midwives interviewed appear to come from the referrals of existing, satisfied clients.) Develop an expanded "package" of clinic level marketing activities that becomes part of the franchise system.

- Develop and disseminate through some appropriate training channel a "list" of all the "tricks of the trade" currently used successfully by WF midwives to increase their business. For example, commissions to other providers (RHU, hospitals, BHWs, etc.) for referrals; discounts to existing clients for referring new clients, barangay meetings; etc. Other lessons learned in marketing their businesses could be included.

Annex C

PRIORITIZATION OF KEY TASKS: JUNE 2003 - JANUARY 2004

PRIORITIZATION OF KEY TASKS: JUNE 2003 - JANUARY 2004

1. Review and installation of standardized accounting system on a per clinic basis

2. Development of the marketing package and its implementation at the clinic level

3. Setting of business and service delivery growth goals on a per clinic basis
   - Establishment of regular and "independent" auditing procedure for clinic financial (royalty and other fee collection) and service delivery performance

4. Completion of the franchise model including all its costing as well as systems manuals

5. Development of a clear definition of the role of the WFPI and its tasks/benefits to its membership

6. Establishment of conversion fee, discussion of fee, membership concurrence obtained

7. Establishment of low-cost loan mechanism
   - Survey of clinic needs for expansion and/or upgrade
   - Assistance in preparation of necessary financial statements and loan applications

8. Timetable for and completion of existing clinic compliance with new DOH implementing order

9. Recruitment of WFPI board members and key staff

Annex D

TABLES I - VI

Table I

NUMBER OF WFMC CLINICS AS OF APRIL 24, 2003

NGO	TOTAL OPERATING CLINICS		TOTAL	PROPOSED NEW CLINICS 2003
	MIDWIVES OWNED	NGO-OWNED		
IMCH	56	1	57	5
NORFI	18	1	19	4
IMCCSDI	24	1	25	4
NORFIL	0	10	10	0
HFC	12	1	13	3
CFPOI	19	1	20	0
DMSF-CERDH	25	1	26	2
COMDEV	29	1	30	3
LEFADO	9	1	10	1
GRAND TOTAL	**192**	**18**	210	**22**

Table II

WFMC Training Costs

WFMC TRAINING

TRAINING	No. of Days	Cost/Trainee (min 15)	Cost Includes
PRE-OPERATION			
Basic/Comprehensive Family Planning Training	35	43,500.00	participants' board and lodging, materials, transportation, resource persons fees.
Interpersonal Communication Skills	4	11,500.00	participants' board and lodging, materials, resource fees.
Family Planning Counseling	4	11,500.00	participants' board and lodging, materials, resource fees.
ON-THE-JOB			
Ambulatory Health Facility Management	4	7,800.00	participants' board and lodging, materials, resource fees.
Suturing Perineal Laceration and Intravenous Insertion	14	11,500.00	tuition fee and per diem (using out-of-town rate)
Training in Obstetric Emergencies *	2	3,500.00	participants' board and lodging (overnight only), materials, consultant's fees
WFMC Reporting and Monitoring System/Bookkeeping	2	2,500.00	participants' board and lodging (overnight only), materials
WFMClinic Business Planning Workshop	2	2,500.00	participants' board and lodging (overnight only), materials
	67	**94,300.00**	

Table III

COST OF EQUIPMENT/INSTRUMENTS FOR WFMC CLINIC

SUMMARY LIST OF FP & MCH INSTRUMENTS & EQUIPMENT				
	ITEM	UNIT PRICE	QUANTITY	TOTAL
FP Instruments	Stethoscope	1,380.00	1	1,380.00
	Sphymomanometer	5,040.00	1	5,040.00
	Kelly Pad	540.00	1	540.00
	Uterine Forceps	1,590.00	1	1,590.00
	Thermometer	17.00	1	17.00
	Pap Smear Kit	2,154.00	1	2,154.00
	Uterine Sound*	500.00	3	1,500.00
	Instrument tray w/ cover	540.00	1	540.00
	Instrument tray w/o cover	576.00	1	576.00
	Straight/picking forceps 10"*	183.34	3	550.02
	Tenaculum*	283.34	3	850.02
	Ovum forceps*	433.34	4	1,733.36
	Vaginal speculum, medium*	220.00	11	2,420.00
	Vaginal speculum, large*	1,020.00	1	1,020.00
	Surgical scissors (curve)	260.00	4	1,040.00
	Iodine cup S.S.	96.00	1	96.00
	Pan emesis S.S.	240.00	1	240.00
	Jar w/ cover S.S. or glass (medium)	150.00	1	150.00
	Jar w/o cover S.S. or glass	150.00	1	150.00
	Sub-total			**21,586.40**
FP Equipment	Foot stool	2,700.00	2	5,400.00
	Medicine Cabinet	6,500.00	1	6,500.00
	Electric Fan (wall or stand) 10"	1,200.00	2	2,400.00
	Sterilizer	6,000.00	1	6,000.00
	Electric Stove	1,500.00	1	1,500.00
	Instrument Table and Chair	6,598.00	1	6,598.00
	Weighing Scale	2,990.00	1	2,990.00
	Flashlight w/ Stand	400.00	1	400.00
	Gooseneck Lamp	1,980.00	1	1,980.00
	Sub-total			**33,768.00**
FP Furniture	Examining Table (Hamilton)	10,000.00	1	10,000.00
	Examining Chair	2,500.00	1	2,500.00
	Linens		2	-
	Office table	550.00	2	1,100.00
	Chair	1,850.00	5	9,250.00
	Bench / stacking chairs	327.00	3	981.00
	Cabinet (closed)	1,050.00	1	1,050.00
	Filing cabinet 4 drawers	2,500.00	1	2,500.00
	Sub-total			**27,381.00**
TOTAL FP INSTRUMENTS, EQUIPMENT AND FURNITURE				**82,735.40**

	ITEM	UNIT PRICE	QUANTITY	TOTAL
MCH Instruments	Standby Baumamanometer	11,500.00	1	11,500.00
	Kelly pad	540.00	1	540.00
	Stainless tray with cover	792.00	1	792.00
	Surgical scissors (straight)	780.00	1	780.00
	Needle holder	780.00	3	2,340.00
	Stainless bowl (kidney shaped)	240.00	3	720.00
	Haemeostatic forceps	780.00	5	3,900.00
	Rubber suction bulb	60.00	1	60.00
	Sponge holding forceps	780.00	3	2,340.00
	Stainless bowl (round)	300.00	3	900.00
	Tissue forceps 6" (regular)	360.00	3	1,080.00
	Sub-total			**24,952.00**
MCH Equipment	20 lbs. Oxygen Tank	1,900.00	1	1,900.00
	Oxygen Regulator	2,500.00	1	2,500.00
	Sunction Machine w/ Gauge	3,900.00	1	3,900.00
	Baby Weighing Scale	3,800.00	1	3,800.00
	Stethoscope	1,380.00	1	1,380.00
	Ambu Bag (US)	3,700.00	1	3,700.00
	Breasfeeding Tray	280.00	1	280.00
	IV Stand	780.00	1	780.00
	Portable emergency light/flashlight	720.00	1	720.00
	Gooseneck lamp	1,338.00	1	1,338.00
	Instrument table	2,100.00	1	2,100.00
	Electric Fan	700.00	1	700.00
	Foot Stool	1,680.00	1	1,680.00
	Sub-total			**24,778.00**
MCH Furniture	OB Table -- Senn Type	4,500.00	1	4,500.00
	Mayo Table	1,700.00	1	1,700.00
	Revolving Stool	1,550.00	1	1,550.00
	Bassinet	2,100.00	1	2,100.00
	Bed	1,480.00	1	1,480.00
	Chair	1,850.00	1	1,850.00
	Bedside table	795.00	1	795.00
	Sub-total			**13,975.00**
TOTAL MCH INSTRUMENTS, EQUIPMENT AND FURNITURE				**63,705.00**
GRAND TOTAL				**146,440.40**

Table IV-A

Cost Estimate (Standard 20sqm)
New Construction

	Description	Qty	Unit	Material Cost	Labor Cost	Amount
I	Excavation	1	lot	0	460	460.00
II	Concreting	6.7	m3	13400	2345	15,745.00
III	Rebars	713	kg	11764.5	2495.5	14,260.00
IV	Formworks	13.5	m2	3240	1620	4,860.00
V	6" CHB	54.4	m2	11968	4896	16,864.00
VI	4" CHB	10.4	m2	1456	936	2,392.00
VII	Plastering	111.5	m2	6690	8920	15,610.00
VIII	Roofing	1	lot	6210	1870	8,080.00
IX	Architectural Finishes					
1	Flooring (0.3mx0.3m Vinyl Tiles)	30	m2	6000	600	6,600.00
2	Ceiling (6mm Plywood)	30	m2	8400	4500	12,900.00
3	Partition (6mm Plywood)	24	m2	7800	3600	11,400.00
4	Painting					
a	Ceiling	30	m2	2100	1200	3,300.00
b	Interior Walls	120	m2	9600	6000	15,600.00
5	Flush Doors	5	sets	10000	1000	11,000.00
6	Hardware (locksets, hinges)	1	lot	1500	75	1,575.00
7	Steel Casement Windows (0.6mx0.6m) (1.2mx1.2m)	1	lot	3420	500	- 3,920.00
XI	Plumbing Works	1	lot	8100	10000	18,100.00
XII	Electrical Works	1	lot	8400	12000	20,400.00
	Total			120049	63017.5	183,066.00

NOTE: NO EXISTING STRUCTURE

Table IV-B

Cost Estimate (Standard 20sqm)

Rennovation

	Description	Qty	Unit	Material Cost	Labor Cost	Amount
I	Architectural Finishes					
1	Flooring (0.3mx0.3m Vinyl Tiles)	30	m2	6000	600	6,600.00
2	Ceiling (6mm Plywood)	30	m2	8400	4500	12,900.00
3	Partition (6mm Plywood)	24	m2	7800	3600	11,400.00
4	Painting			0	0	-
a	Ceiling	30	m2	2100	1200	3,300.00
b	Interior Walls	120	m2	9600	6000	15,600.00
5	Flush Doors	5	sets	10000	1000	11,000.00
6	Hardware (locksets, hinges)	1	lot	1500	75	1,575.00
7	Steel Casement Windows			0	0	-
	(0.6mx0.6m) (1.2mx1.2m)	1	lot	3420	500	3,920.00
II	Plumbing Works	1	lot	8100	10000	18,100.00
III	Electrical Works	1	lot	8400	12000	20,400.00
	Total			65320	39475	104,795.00
	Exterior Painting (Façade only)	13	m2	1300	650	1,950.00

NOTE: EXISTING STRUCTURE - CONCRETE WALL, FLOOR, ROOFING

Table V

Summary of WFMC's Gross Revenue Performance: January 1, 2002-December 31, 2002

Regional Summary

	2002 Monthly Revenue Components				
Region	**% Deliv**	**%Antenatal**	**% FP**	**% Immun**	**% Others**
NCR & Region IV / IMCH	55%	**4%**	**6%**	**5%**	**30%**
Region III (BULACAN) IMCCSDI	43%	**2%**	**7%**	**4%**	**44%**
Region III (Pampanga & Nueva Ecija) Norfil	n/a	na	n/a	n/a	n/a
Region IV/ NORFI	45%	3%	13%	8%	32%
Region VII (CFPOI)	55%	3%	9%	3%	29%
Region VIII (LEFADO)	38%	4%	14%	4%	38%
Region X & Craga/ IMCCSDI	32%	3%	22%	2%	41%
Region XI/ DMSF	44%	5%	8%	11%	33%
Region XII/COMDEV	40%	2%	12%	8%	38%
Region XII & Expanded ARMM	47%	4%	6%	1%	43%

Table VI -A

WFMC's Sales and Operating Cost Performance
January 1, 2003 – December 31, 2003

	Midwife	NGO	CLINIC START MONTH	CLINIC START YEAR	OP COST*	OP PROFIT	ANNUAL GROSS	MONTHLY GROSS
1	MILLAN CAROLINA _	IMCH	April	1997	587,619	1,623,549	2,211,168	245,685
2	CASPE _ FLORDELIZA, R.M.	IMCH	April	1998	417,546	667,402	1,084,948	120,550
3	BOCALBOS _ HERLYN	IMCH	November	2000	604,605	354,656	959,261	106,585
4	MANGAHAS S. LOURDES	IMCCSDI	May	1998	712,812	545,799	1,258,611	104,884
5	LUDERICO GERTRUDES C.	IMCH	November	2000	485,088	348,142	833,230	92,581
6	DE LOS SANTOS _ ESTRELITA	IMCH	April	1997	227,886	470,821	698,707	77,634
7	SILVA VIRGINIA	IMCH	July	2002	305,495	114,528	420,023	70,004
8	DANTES _ PURITA	IMCH	November	2000	317,910	295,612	613,522	68,169
9	DELFIN T. LOLITA	DMSF	April	1997	273,074	511,441	784,515	65,376
10	BERMEJO _ MARILYN	NORFI	March	2001	413,244	338,728	751,972	62,664
11	BESANA B. ALICIA	COMDEV	May	1997	425,681	322,481	748,162	62,347
12	QUILARIO N. FLORAME	CFPOI	May	1998	347,563	384,118	731,681	60,973
13	VICENCIO _ VIOLETA, RM	IMCH	April	1998	153,000	391,517	544,517	60,502
14	TIAMSON _ EDNA	IMCH	January	2001	57,300	481,491	538,791	59,866
15	BACUS B. LOLITA	CFPOI	May	1998	282,175	421,927	704,102	58,675
16	CONGRESO S. ERLINDA	IMCH	October	2000	339,286	178,595	517,881	57,542
17	MEDRANO _ EDERLYN	DMSF	April	1998	252,027	431,968	683,995	57,000
18	MORALLAS _ MARIA TERESA	DMSF	April	1997	135,358	525,089	660,447	55,037
19	PAKONG _ NORIA	COMDEV	November	2000	291,620	365,429	657,049	54,754
20	DARIA A. NAZARINA	CFPOI	April	1997	290,338	363,628	653,966	54,497
21	VILLAMOR CLARITA _	IMCH	September	2001	290,812	196,385	487,197	54,133
22	BARELA _ MONICA	COMDEV	November	1997	271,450	359,793	631,243	52,604
23	BOLUSO _ ELMA	NORFI	October	2000	397,271	222,852	620,123	51,677
24	TAMAYO _ DULCE	IMCH	January	1999	163,537	299,372	462,909	51,434
25	FORTO-JOSEPH _ LINIELYN	IMCH	September	1999	328,198	130,746	458,944	50,994
26	DIAZ _ REBECCA	IMCH	December	2000	175,000	283,085	458,085	50,898
27	VILLAR _ ROSALINDA	IMCH	November	2000	250,848	200,601	451,449	50,161
28	ZALDARIAGA MA. LERWIN S.	IMCH	December	2000	353,006	96,109	449,115	49,902
29	SANCHEZ P. ARMIDA	IMCH	March	2000	105,800	338,021	443,821	49,313

Table VI-B

WFMC's Sales and Operating Cost Performance
January 1, 2003 – December 31, 2003

30	EMPAY _ PURIZA	IMCH	April	1997	129,650	298,942	428,592	47,621
31	FLORES _ YOLANDA	IMCCSDI	September	1999	464,168	77,282	541,450	45,121
32	EDILLOR _ LORNA	IMCH	April	1997	213,968	190,861	404,829	44,981
33	MONTIBOR _ EDITH	NORFI	April	1998	387,249	152,231	539,480	44,957
34	AMURAO _ MIRAFLOR, RM	IMCH	April	1998	181,306	205,398	386,703	42,967
35	CABRERA Y. NORMA	CFPOI	June	1999	221,325	293,279	514,605	42,884
36	INOPIA _ LENIE	COMDEV	December	2000	335,730	171,069	506,799	42,233
37	CORDERO _ ELDA	IMCH	January	2001	152,253	215,636	367,889	40,877
38	DELA CRUZ _ HELEN	IMCH	April	1997	216,515	151,253	367,768	40,863
39	UY P. NANELITA	CFPOI	June	2000	113,787	375,958	489,745	40,812
40	VILLASEÑOR _ ALICIA	IMCH	December	2000	113,200	251,741	364,941	40,549
41	ROMULO G. ROSITA	IMCH	October	2000	124,695	231,318	356,013	39,557
42	AMOIN _ GLORIA	IMCH	October	1999	190,000	160,650	350,650	38,961
43	ROMERO _ ESTERLITA	IMCH	November	2000	91,760	246,824	338,584	37,620
44	CABAJAR A. MELODINA	CFPOI	July	2000	220,921	227,410	448,331	37,361
45	PASCUA _ CORAZON	IMCH	April	1997	48,163	281,924	330,087	36,676
46	NIQUE _ JOYCELEN	DMSF	April	1998	301,945	132,040	433,985	36,165
47	CANCHICO FELY V.	NORFI	October	1999	230,814	179,334	410,148	34,179
48	AUSTARI _ RENEMEE	IMCH	October	2000	64,540	229,410	293,950	32,661
49	ALOJADO _ ANITA	DMSF	April	1997	213,300	178,610	391,910	32,659
50	PAMINTO _ EVA	NORFI	October	2000	371,719	15,106	386,826	32,235
51	MAGDADARO _ MERCEDES	DMSF	April	1998	84,038	293,368	377,405	31,450
52	MENDOZA E. EVELYN	CFPOI	May	1999	152,325	217,872	370,197	30,850
53	OCAMPO JASMIN _	IMCH	September	2001	37,852	234,449	272,301	30,256
54	GONZALES REMEDIOS E.	IMCCSDI	May	1998	200,488	155,537	356,025	29,669
55	DE CASTRO EDNA G	COMDEV	April	1997	241,891	108,820	350,711	29,226
56	PANILA NEMAH	IMCH	August	2002	103,977	11,072	115,049	28,762
57	NACIONGAYO _ ROSELYN	NORFI	November	2000	224,641	118,032	342,673	28,556
58	RAYMUNDO _ FLORDELIZA	IMCCSDI	May	1998	245,750	95,100	340,850	28,404
59	BEBER _ MERLENITA	NORFI	April	1999	226,732	111,564	338,296	28,191
60	PAGHUBASAN MORENA NOMA	IMCH	October	1999	120,921	132,476	253,397	28,155

Table VI-C

WFMC's Sales and Operating Cost Performance
January 1, 2003 – December 31, 2003

61	MONTALBAN _ WILMA DONNA	IMCH	January	1999	135,863	106,258	242,121	26,902
62	ROADEL _ AIDA, R.M., R.N.	IMCH	April	1998	148,995	87,020	236,015	26,224
63	PLAZA _ JOCELYN	IMCCSDI	October	1998	228,423	81,205	309,629	25,802
64	BARCELO _ DORCAS, R.M.	IMCH	April	1998	89,030	138,970	228,000	25,333
65	URBANO _ TERESITA	COMDEV	November	2000	193,902	107,406	301,308	25,109
66	MONTEIRO_MA. LIZA	DMSF	May	1998	121,842	100,431	222,272	24,697
67	HERNANDEZ MERLINE _	IMCH	July	2001	159,633	61,700	221,333	24,593
68	QUINES EVELYN C	COMDEV	April	1997	217,178	77,152	294,330	24,528
69	CIDRO _ VIRGINIA	IMCH	October	1999	105,000	113,643	218,643	24,294
70	MIRANDA C. MA. CRISANTA	IMCCSDI	May	1999	158,404	131,914	290,319	24,193
71	RAMONES TERESITA G	COMDEV	November	1999	98,560	190,378	288,938	24,078
72	RAMIREZ _ FE	DMSF	April	1997	163,090	123,973	287,063	23,922
73	PASIA _ VIRGINIA	IMCH	December	2000	34,120	178,389	212,509	23,612
74	DEPLA P. FLORDELIZA	IMCCSDI	May	1998	196,717	80,716	277,433	23,119
75	CABUHAT LUCY	IMCCSDI	October	2002	36,116	31,746	67,862	22,621
76	DE LA CRUZ-ROBLES _ FRANCESCA	IMCH	October	2000	166,405	36,028	202,433	22,493
77	RASONABLE _ TESSIE	DMSF	April	1997	137,880	120,956	258,836	21,570
78	SALAUM _ ZENAIDA	IMCCSDI	June	1998	109,957	147,682	257,639	21,470
79	DAGATAN-DOLORITO _ NERISSA	DMSF	May	1998	81,827	175,122	256,949	21,412
80	SIMON _ NELECIA	NORFI	March	2001	157,369	98,672	256,041	21,337
81	ALBAÑO _ MERLYN FLOR	CFPOI	October	2001	68,395	186,555	254,950	21,246
82	ENRIQUEZ JOY EDEL G	COMDEV	November	1998	133,051	119,012	252,063	21,005
83	CAMERO CRISTINA	IMCH	November	2000	189,300	(2,200)	187,100	20,789
84	SANTOS GENEROSA	IMCH	February	2001	122,373	117,987	240,360	20,030
85	LIBOON _ VILMA	COMDEV	November	2000	101,775	138,327	240,102	20,009
86	SUAZO C. GENEVIEVE	CFPOI	April	1997	100,695	137,839	238,534	19,878
87	VALENCIA D BELLA	NORFI	October	1999	137,398	95,798	233,196	19,433
88	SANCHEZ _ JULIET	LEFADO	July	1999	145,247	82,435	227,682	18,974
89	PEREZ _ ELIZABETH	IMCH	April	2001	141,471	27,688	169,159	18,795
90	TELEBRICO _ JOCELYN	IMCH	October	2000	58,944	105,724	164,667	18,296
91	BADE _ ALMA	IMCCSDI	January	1998	49,444	168,348	217,792	18,149

Table VI-D

WFMC's Sales and Operating Cost Performance
January 1, 2003 – December 31, 2003

92	VILLALON M. FRANCISCA	CFPOI	August	2000	87,712	129,529	217,241	18,103
93	BERATO _ GENEVIEVE	DMSF	November	2000	122,703	91,928	214,631	17,886
94	VILLEGAS C. MARILOU	IMCH	November	2000	96,639	63,465	160,104	17,789
95	MAYO PAPALA A.	HFC	November	2001	70,910	142,386	213,296	17,775
96	RANIS _ JULIETA	COMDEV	January	2001	169,648	41,226	210,874	17,573
97	SALCEPUEDES HELEN M	COMDEV	May	1997	157,035	51,210	208,245	17,354
98	RIVAS MA CECILIA B	IMCH	July	2002	375,589	(272,144)	103,446	17,241
99	SIOSON S. NENITA	COMDEV	January	2001	101,203	95,042	196,244	16,354
100	CINCO MARITESS AGOTE	LEFADO	December	1998	125,194	70,572	195,766	16,314
101	GELITO _ MELBA	DMSF	April	1997	67,635	128,053	195,688	16,307
102	TOLENTINO _ BERNADETTE	IMCH	December	2000	71,000	74,735	145,735	16,193
103	RANAO _ JOJIE	DMSF	May	1998	152,737	40,628	193,366	16,114
104	VELAYO TERESITA	IMCH	August	2002	40,111	23,607	63,718	15,930
105	COSADIO _ RHODORA	DMSF	April	1997	104,964	82,943	187,907	15,659
106	PARAISO D.C. SUSANA	IMCCSDI	May	1998	107,029	77,601	184,630	15,386
107	SANTIAGO B. MA. TERESA	IMCH	February	2001	92,732	42,757	135,490	15,054
108	IGNORO _ JUDITH	DMSF	April	1999	95,929	82,622	178,551	14,879
109	ESCABARTE _ MARILYN	DMSF	May	1998	117,383	57,986	175,369	14,614
110	FERNANDO MARIFE E.	IMCCSDI	September	2001	141,588	32,502	174,089	14,507
111	MONTEVERDE LORENA	IMCH	July	2002	44,468	26,530	70,998	14,200
112	JAYME-DIMAYMAY _ SABRENA	CFPOI	April	1997	106,997	60,080	167,077	13,923
113	GRUMACON _ MERLINA	DMSF	February	2001	101,189	65,204	166,393	13,866
114	GEVERA GRACE A	COMDEV	May	1997	123,940	40,373	164,313	13,693
115	GAMALIER _ REBECCA	CFPOI	February	1999	33,992	128,230	162,222	13,519
116	RENOMERON _ FLORENCIA	LEFADO	April	1999	67,834	92,744	160,578	13,381
117	PARAS _ ROSALIE	CFPOI	April	1997	85,585	73,525	159,110	13,259
118	ALBA _ CARLA	IMCH	September	1999	101,561	17,393	118,954	13,217
119	GARAY_ALPHA	COMDEV	September	1999	136,155	22,360	158,514	13,210
120	PRECIOSO _ MA. THERESA	NORFI	July	1999	84,046	73,344	157,390	13,116
121	DIESTRO _ CHERELYN	NORFI	March	2001	129,914	26,529	156,443	13,037
122	MELINDO ANALIS	DMSF	October	2002	27,078	11,826	38,905	12,968

Table VI-E

WFMC's Sales and Operating Cost Performance
January 1, 2003 – December 31, 2003

123	BOCAOCO _ LOURDES	DMSF	July	1999	78,488	76,967	155,455	12,955
124	YSULAN _ ANGELICA	NORFI	March	2001	145,885	8,301	154,186	12,849
125	CORTEZ _ CHARINA	IMCCSDI	April	1997	140,840	12,851	153,691	12,808
126	ESTEBAN _ CORAZON	COMDEV	December	2000	87,358	65,429	152,787	12,732
127	RAMOS ANNALISA	IMCH	July	2002	81,072	(5,310)	75,762	12,627
128	TAVERA ROSA MEMBRANO	LEFADO	May	1998	101,541	49,727	151,268	12,606
129	CAMINADE _ JACQUELINE**	DMSF	October	2002	25,823	11,794	37,618	12,539
130	SANTOS _ ALICIA	IMCH	December	2000	60,148	52,541	112,689	12,521
131	PALIMA _ DIANNE	LEFADO	August	1999	124,000	23,335	147,335	12,278
132	ESTRERA _ ROSELLE	LEFADO	November	2000	65,147	75,106	140,253	11,688
133	CANTIVEROS ARLEEN	CFPOI	October	2002	23,707	10,117	33,824	11,275
134	PINEDA IMMACULADA	NORFI	August	2002	23,410	32,742	56,152	11,230
135	DIOSANA OLIVA _	NORFI	March	2002	55,749	77,655	133,404	11,117
136	VILCHES _ PERLITA ARMIAN	CFPOI	April	1999	83,759	48,506	132,264	11,022
137	CABASE LYN	DMSF	October	2002	21,947	11,064	33,011	11,004
138	LUGAR C. SUZETTE	DMSF	May	1998	103,124	21,929	125,053	10,421
139	OMAMALIN M. ANITA	IMCCSDI	June	1998	111,162	10,453	121,615	10,135
140	BARRERA _ NILA	COMDEV	January	2001	43,806	77,515	121,321	10,110
141	SUMILE ANALIZA	DMSF	October	2002	14,492	15,504	29,996	9,999
142	BAYONETA _ LOLITA	NORFI	April	1998	101,213	16,204	117,417	9,785
143	INOCENTES _ BETTY	COMDEV	February	2001	47,518	67,809	115,328	9,611
144	MERCADO S. ELIZABETH	IMCCSDI	April	1997	86,140	24,182	110,322	9,193
145	CAHAYAG M. JASMIN	IMCCSDI	May	1999	93,790	15,780	109,570	9,131
146	LAURON LEAN	CFPOI	August	2002	52,405	(7,592)	44,813	8,963
147	SUROPIA _ MERCEDES	COMDEV	November	2000	81,414	24,422	105,836	8,820
148	LOYOGOY S. BLESILDA	LEFADO	May	1998	71,544	31,682	103,226	8,602
149	BLANCO V. ELDA	IMCCSDI	April	1997	72,281	28,183	100,464	8,372
150	TERRIBLE KAREN	IMCH	July	2002	34,430	15,449	49,879	8,313
151	NADELA S. ANNABELLE	IMCCSDI	April	1997	50,919	48,835	99,754	8,313
152	CAMPOSANO TEODORA**	IMCH	July	2002	51,448	(1,753)	49,695	8,283

Table VI-F

WFMC's Sales and Operating Cost Performance
January 1, 2003 – December 31, 2003

153	JABINES FROLINE	COMDEV	November	1999	25,935	31,282	57,217	8,174
154	PEREZ _ NEMIA	DMSF	April	1998	63,902	33,721	97,622	8,135
155	LOZANO LUDEVINA	IMCCSDI	December	2002	3,505	4,355	7,860	7,860
156	ALEJANDRO M. EMELITA	IMCCSDI	May	1998	45,498	45,472	90,970	7,581
157	LANGANLANGAN EVELYN P.	HFC	September	2001	38,554	52,165	90,719	7,560
158	TANUGA MA FE**	NORFI	July	2002	27,878	17,123	45,001	7,500
159	CANATA SUSANA	CFPOI	October	2002	21,790	(20)	21,770	7,257
160	PASUQUIN MA. FE. A.**	COMDEV	September	2002	18,429	10,584	29,013	7,253
161	ACUNA-ENRILE _ NELMIDA	IMCCSDI	May	1998	38,660	46,925	85,585	7,132
162	CAÑETE JOCELYN T.	HFC	September	2001	55,884	29,637	85,521	7,127
163	ANDING FE MARY JANE	HFC	August	2002	43,798	(8,484)	35,314	7,063
164	ERESE EDNA	IMCH	June	2001	87,000	(4,310)	82,690	6,891
165	ABANES ALICE _	IMCH	September	2001	718,222	(657,452)	60,770	6,752
166	PEDROSO DOLORES	NORFI	September	2002	22,929	3,898	26,827	6,707
167	MAGSAKAY BENEFRIDA	IMCCSDI	December	2002	5,600	890	6,490	6,490
168	IGNACIO LORELYN P	HFC	September	2002	10,525	14,529	25,054	6,263
169	BITON _ VILMA	COMDEV	November	2000	38,745	36,260	75,005	6,250
170	SUMAMPONG JULITINIA**	CFPOI	October	2002	26,823	(15,188)	11,635	5,817
171	ATIG DELIA REFESADA	IMCCSDI	March	1999	32,282	29,736	62,018	5,168
172	AMOD TERESA	DMSF	November	2002	5,609	3,749	9,358	4,679
173	MAESTRE JENNYVI**	IMCCSDI	November	2002	18,704	(9,414)	9,290	4,645
174	TRIAMBULO MARIVEL	HFC	July	2002	57,748	(32,836)	24,912	4,152
175	SALINAS _ HILDA	LEFADO	February	2001	28,151	20,372	48,523	4,044
176	BADRINA GRACE	NORFI	August	2002	27,974	(9,704)	18,270	3,654
177	ARIATE A. ELIZABETH	COMDEV	February	2001	14,112	27,908	42,020	3,502
178	DEMETERIO A. SANDRA	CFPOI	August	1999	28,655	13,168	41,823	3,485
179	HOMENA _ NANCY	COMDEV	November	2000	10,751	29,630	40,381	3,365
180	OPLE-CANOY OFELIA A	HFC	April	2002	16,454	11,547	28,001	3,111
181	ESPINOSA ALFRED	DMSF	October	2002	6,999	2,220	9,218	3,073
182	RELATORRES CATALINA	LEFADO	October	2002	6,445	(405)	6,040	3,020
183	FUENTES THELMA	HFC	April	2002	45,991	(19,320)	26,672	2,964

Table VI-G

WFMC's Sales and Operating Cost Performance
January 1, 2003 – December 31, 2003

184	MANANSALA SARAH	DMSF	October	2002	14,385	(5,614)	8,772	2,924
185	ABALORIO CORAZON	HFC	April	2002	50,983	(25,550)	25,434	2,826
186	ACO-ON JAMAILAH S.	HFC	April	2002	3,400	20,585	23,985	2,665
187	BATOLEÑO MUERA A.**	HFC	September	2001	104,274	(72,727)	31,547	2,629
188	BATI-ON NOREYLIN P	HFC	April	2002	61,112	(42,211)	18,901	2,100
189	BARLOA MA ISABEL	HFC	April	2002	53,467	(34,622)	18,845	2,094
190	JUANITEZ BERNADITH**	LEFADO	October	2002	15,394	(14,239)	1,155	578
191	NILLAS SYLVIA	CFPOI	December	2002	0	0	0	0
192	CRUZ DAISY	COMDEV	October	2002	0	0	0	0
193	MIPARANUM SHIRLEY	COMDEV	December	2002	0	0	0	0
194	ABELLO PERLITA**	NORFIL	September	2002				
195	DIMALI ROSALINDA**	NORFIL	September	2002				
196	GALACGAC ELMIRA**	NORFIL	September	2002				
197	LOPEZ NERISSA**	NORFIL	September	2002				
198	MALACA MARIVIC**	NORFIL	September	2002				
199	MANSILLA NORMA**	NORFIL	September	2002				
200	MAURICIO JEANETTE**	NORFIL	September	2002				
201	MUYOT LEONISA**	NORFIL	September	2002				
202	PALABASAN PERLITA**	NORFIL	September	2002				
203	WAJE MA CRISTINA**	NORFIL	September	2002				

*

Direct Materials, Direct Labor, Clinic Overhead (utilities, cleaning supplies, laundry), Indirect Labor, rental, communications, office supplies, transportation expenses, ads and promo costs, training expenses, insurance expenses, licenses and fees, repair and maintenance expenses, miscellaneous

** Currently managing NGO-owned clinic. Cost/Revenue of 8 clinics not yet recorded

Annex E

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SELECTED BIBLIOGRAPHY: TANGO II PROJECT DOCUMENTS, UNPUBLISHED STUDIES, AND MANUALS

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